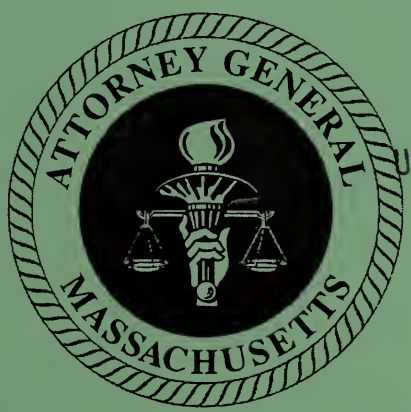
THE ATTORNEY GENERAL'S COMMUNITY BENEFITS GUIDELINES FOR HEALTH MAINTENANCE ORGANIZATIONS



January, 2000

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Dear friends and colleagues:

It is with great pleasure that I reissue the *Attorney General's Guidelines for Health Maintenance Organizations.*

The HMO guidelines were first published in February 1996 from a collaboration between the HMO industry, community and health care advocates and the Attorney General's Office. Their goal is to promote efforts by HMOs, working with their communities, to develop and support programs that improve the quality of life and address the unmet health care needs of working families and populations at risk. The guidelines are process-oriented: they emphasize needs assessment, program evaluation, and the importance of including meaningful community participation at all stages. The Guidelines strongly encourage HMOs to target the special needs of the poor, the elderly, children, racial, linguistic and ethnic minorities, refugees, immigrants and people who are physically or cognitively impaired.

The Commonwealth's HMOs often receive recognition for being among the best in the nation in the care they provide to their members. They also deserve commendation for their leadership and participation in this non-regulatory, voluntary approach to Community Benefits that is a national model. Since the inception of the guidelines, every Massachusetts HMO has published annual reports reflecting the substantial accomplishments to improving access to health care, as well as identifying the need for future progress.

Although Community Benefits alone cannot be expected to solve the critical problems facing our health care system, they are an important part of the safety net we have fashioned to support the most vulnerable members of our community. At a time when every sector of the health care system is under great financial strain, it will require creativity, innovation and leadership on the part of HMOs and hospitals to make sure that the Community Benefits initiative continues in a meaningful way.

I look forward to working in partnership with the HMO industry and community organizations in any way I can to support Massachusetts HMOs' continued commitment to Community Benefits.

Sincerely,

Tom Reilly

COMMUNITY BENEFITS GUIDELINES FOR HEALTH MAINTENANCE ORGANIZATIONS

TABLE OF CONTENTS

THE ATTORNEY GENERAL'S COMMUNITY BENEFITS GUIDELINES FOR HEALTH MAINTENANCE ORGANIZATIONS

I. INTRODUCTION

A. Background

The health care marketplace, in Massachusetts and across the country, is evolving quickly and dramatically. Health care providers and insurers are reducing fragmentation in the delivery of care through various forms of integration. While the ultimate shape of the restructured system is still to be determined, health maintenance organizations ("HMOs") will certainly play a key role. In Massachusetts, HMOs have made major gains in recruiting new members, and as a result, have become a critical component in the delivery of health care services to a significant portion of consumers across the state.

Given their increasingly important role in providing or arranging for the provision of health care in the Commonwealth, HMOs, irrespective of their model type or organizational status, have acknowledged their corporate responsibility to do all that they can to improve and maintain the health status of members of the communities they serve. These Community Benefits Guidelines are intended to establish and formalize voluntary principles to guide the HMOs' community benefits programs and to encourage HMOs' continued commitment to disadvantaged patient populations in this time of both cost containment and dwindling public resources.

B. Role of the Attorney General

The impact of problems in the health care system are felt virtually everywhere in the Office of the Attorney General. One of the priorities of the Attorney General has been to use the law enforcement powers of the office to address a broad range of health care cases and issues. With the failure of federal health care reform, the health care system remains complicated, piecemeal, expensive, and difficult to navigate.

The Attorney General's Regulated Industries Division represents the interests of consumers in advocating for lower rates for non-group and Medigap policies. Along with the Regulated Industries Division, the Consumer Protection and Antitrust Division prosecutes unfair trade practices in the health care marketplace. This Division prosecutes scam artists who prey on elderly and other vulnerable consumers by selling them unnecessary or defective health care products or bogus insurance policies. The Consumer Protection and Antitrust Division also applies antitrust laws to hospitals, HMOs, and other providers in mergers and joint ventures to protect the public from anti-competitive practices. The Medicaid Fraud Control Unit prosecutes those who commit Medicaid Fraud. The Family and Community Crimes Bureau is involved with and addresses the health care issues raised by the violence, domestic and urban, in our society. Through the Division of Public Charities, the Attorney General has broad statutory oversight responsibilities to ensure that all charitable organizations in the Commonwealth, including not-for-profit HMOs, account for their funds and conduct themselves in a manner consistent with their benevolent mission.

Thus, consistent with the broad oversight and specific responsibilities of the Office of the Attorney General, these Community Benefits Guidelines for HMOs are recommended for all HMOs licensed under Massachusetts General Laws, Chapter 176G, Section 1. The Guidelines were developed in consultation with providers, community groups, and HMOs to serve as a set of formal principles to support the development of community benefits plans by HMOs operating in the Commonwealth. These Guidelines may be used by HMOs to help focus their role in helping to meet the growing and pressing health care needs of underserved or underinsured populations. The Attorney General recognizes the existing community benefits programs sponsored by many HMOs and hopes that these principles inspire even greater efforts.

II. HMO COMMUNITY BENEFITS PRINCIPLES

HMOs are encouraged to develop community benefits intended to promote preventive care and to improve the health status and quality of life for working families and populations at risk, whether or not those individuals are currently HMO members. The Attorney General expects that the public health focus of the following principles will support HMOs in serving the needs of the communities within their geographic service areas and particularly the needs of the medically underserved:

A. **The governing body of each HMO should adopt and make public a Community Benefits Policy Statement setting forth its commitment to a formal Community Benefits Program.**

B. **The governing body and senior management of the HMO should be responsible for overseeing the development and implementation of the Community Benefits Program, the resources to be allocated, and the administrative mechanisms for the regular evaluation of the Program.**

C. **The governing body and senior management of the HMO should seek assistance and participation from HMO members and the community in developing and implementing the HMO's Community Benefits Program, and in defining the targeted population and the specific health care needs to be addressed by the Community Benefits Program.**

D. **Each HMO should develop its Community Benefits Program based upon an assessment of the health care needs and resources of the identified populations, particularly lower- and moderate-income communities. The Program should consider the health care needs of a broad spectrum of age groups and health conditions.**

E. **The HMO should develop and market products which would attract all segments of the population.**

F. **The HMO should strive to offer and promote, consistent with existing laws and regulations, direct enrollment for non-group coverage and continue to work**

toward insurance market reform so that managed care will be an option for all working families and individuals.

G. **The HMO should take steps to reduce cultural, linguistic, and physical barriers to accessible health care at key points of patient contact.**

H. **The HMO should strive to help Massachusetts consumers who are about to lose coverage or who are uninsured, to maintain or obtain, as applicable, health care coverage, at least for limited periods of time, at reduced or subsidized rates.**

I. **The HMO should make an Annual Community Benefits Report available upon request to the public at the HMO and through the headquarters of the Massachusetts Association of HMOs (MAHMO), where the Report will also be available upon request to the public and to the Office of the Attorney General. The Report should describe the HMO's level of community benefits expenditures and describe the HMO's approach to establishing those expenditures.**

III. THE GUIDELINES

A. The governing body of each HMO should adopt and make public a Community Benefits Policy Statement setting forth its commitment to a formal Community Benefits Program.

Each HMO should establish a process to develop and update the Community Benefits Policy Statement approved by its governing body. This Policy Statement should address the HMO's commitment to developing, adopting, and implementing a Community Benefits Program intended to facilitate, encourage, or provide for the delivery of health care services and educational and preventive programs and services to underserved populations in the HMO's service area.

The Policy Statement should recognize the value of productive collaboration with the communities within the HMO's geographic service area. The Policy Statement should publicly acknowledge the HMO's commitment to its community. The Policy Statement for each HMO should be tailored to be compatible with the HMO's organizational structure and model type, as well as the HMO's Corporate culture and strategic vision.

B. The governing body and senior management of the HMO should be responsible for overseeing the development and implementation of the Community Benefits Program, the resources to be allocated, and the administrative mechanisms for the regular evaluation of the Program.

The governing body and senior management of the HMO should be responsible for ensuring that the goals and intent of the Community Benefits Policy Statement are carried out by the HMO. The values embodied in this Statement should be reflected in the HMO Community Benefits Program. The HMO should ensure that the goals and objectives of the Policy Statement are shared

with individuals at every level of the organization so that these goals are reinforced and widely accepted.

Although the governing body and senior management of the HMO should ultimately be responsible for developing and adopting the Policy Statement and ensuring the resource allocation necessary to support the Policy Statement and Community Benefits Program, all employees should be encouraged to take responsibility for the Program's implementation. The HMO should periodically evaluate its Policy Statement and the Community Benefits Program to be sure they complement the HMO's strategic vision and accurately reflect the HMO's community benefits objectives and the managed care focus on preventive care and health promotion.

C. The governing body and senior management of the HMO should seek assistance and participation from HMO members and the community in developing and implementing the HMO's Community Benefits Program, and in defining the targeted population and the specific health care needs to be addressed by the Community Benefits Program.

The HMO should actively seek and encourage collaboration, information, and input from the community and representative organizations. This input or participation should be drawn from various populations and groups within the HMO's geographic service area. The HMO should institute effective community outreach to contact populations which may have been historically under-represented within its member population. The HMO may explore different aspects of "community," as a community may be defined in many ways: territorially, geographically, demographically, or epidemiologically.

D. Each HMO should develop its Community Benefits Program based upon an assessment of the health care needs and resources of the identified populations, particularly lower- and moderate-income communities. The Program should consider the health care needs of a broad spectrum of age groups and health conditions.

The HMO should develop its Community Benefits Program in consultation with the communities it serves. In general, the Program should include goals, needs assessment, implementation time frames, and budget preparation. The HMO may wish to assess community needs and resources in collaboration with area service provider organizations, such as hospitals, other HMOs, community health centers, and social service agencies, taking into account health status data already available. If an HMO is part of an integrated health care system, the system may develop a coordinated Community Benefits Program.

Finally, the HMO should establish a set of priorities of community health care needs and resources. In assessing community needs, the HMO should consider public health data and other health status indicators and consult with representatives of the designated community to identify perceived needs. Using existing data and information will avoid wasteful duplication in assessing community needs. Much information is already collected by hospitals, other HMOs, various public and private entities, and local public health departments, as well as the Department of Public Health, the Department of Mental Health, the Rate Setting Commission, and the Division of Medical Assistance. Attention should be given to the needs of the following special populations: the

working poor; poor children; victims of domestic violence; low-to moderate income elderly; racial, linguistic, and ethnic minorities; and people with physical and cognitive difficulties.

E. The HMO should develop and market products which would attract all segments of the population.

The HMO's Community Benefits Program should allow the HMO to develop product-market strategies which would result in market expansion or diversification in the delivery and financing of health care. The HMO may decide to expand its market by delivering its present products to new populations within its targeted community. Alternatively, the HMO may decide to develop new products to focus on the designated community. In the course of its creating marketing and advertising strategies to implement new or diversified product development strategies, the HMO should avoid marketing and advertising practices which might discourage certain market segments from selecting the HMO as their health plan.

F. The HMO should strive to offer and promote, consistent with existing laws and regulations, direct enrollment for non-group coverage and continue to work toward insurance market reform so that managed care will be an option for all working families and individuals.

The HMO should offer, within applicable laws and regulations, direct enrollment for health care coverage for individuals and families who are not part of any group plan. In addition to providing direct non-group enrollment to the extent currently possible, the HMO should undertake or continue to assert leadership to bring about reform of the health insurance marketplace. HMOs are encouraged to support a fiscally responsible approach to universal coverage, including development of a guaranteed-issue non-group product with no medical underwriting which provides portability of coverage. Such legislation would result in a significant benefit to all citizens of the Commonwealth including communities identified by the HMO in its Community Benefits Program.

G. The HMO should take steps to reduce cultural, linguistic, and physical barriers to accessible health care at key points of patient contact.

HMOs should ensure that linguistic and cultural differences and physical disabilities do not present barriers to accessible health care. HMOs are encouraged to commit to increasing the number of bilingual providers. To the extent possible, within their model types, HMOs should make multilingual staff available and provide qualified professional interpreters at service delivery points and in member services. Member brochures and plan benefits summaries should be printed in languages relevant to significant numbers of consumers in the HMO's service area so as to ensure that disclosure about significant information is appropriately communicated to diverse markets. All HMOs should strive to make telecommunications devices (TTY/TDD) available so that hearing impaired persons can have access to services.

H. The HMO should strive to help Massachusetts consumers who are about to lose coverage or who are uninsured, to maintain or obtain, as applicable, health care coverage, at least for limited periods of time, at reduced or subsidized rates.

A major goal of the HMO's Community Benefits Program should be the HMO's commitment to providing preventive care or subsidized coverage to those who are uninsured and

unable to pay for health care services. An HMO may choose to offer its existing products to the designated community or offer newly developed products. For example, the provision of flu shots to the medically underserved community in anticipation of the flu season would be the provision of a new service which would benefit the community at large by enhancing health status and ultimately reducing health care costs.

The HMO could make a premium subsidy program available to its members. Subsidies could be provided to group members who become eligible for COBRA coverage with the group through which they were members and whose annual household income is less than a certain percentage of the federal poverty level and who are not eligible for Medicare or Medicaid. In this way, the HMO would be helping its own enrollees to maintain health care coverage for some limited period of time at reduced rates. The HMO could also make this program available to some segment of non-members.

I. The HMO should make an Annual Community Benefits Report available upon request to the public at the HMO and through the headquarters of the Massachusetts Association of HMOs (MAHMO), where the Report will also be available upon request to the public and to the Office of the Attorney General. The Report should describe the HMO's level of community benefits expenditures and describe the HMO's approach to establishing those expenditures.

The HMO should prepare an Annual Report on its Community Benefits Program which will be available to the public and which will also be provided to MAHMO, where it will be available to the public upon request and to the Office of the Attorney General. If the HMO is part of an integrated health care system, it may wish to prepare and provide an integrated report. The report will be considered a public record.

The first (interim) Report should be prepared and made available to the public at the HMO and MAHMO by September 30, 1996, setting forth the HMO's Community Benefits Policy Statement and describing the HMO's mechanism for community involvement in the development of the HMO's Community Benefits Program. Thereafter, the annual Report should be prepared and made available to the public at the HMO and at MAHMO by June 30th of each year.

The Report should include the following components:

a. The HMO Community Benefits Policy Statement as adopted by its governing board;

b. The mechanism by which community participation is solicited;

c. Identification of community health care needs that were considered in developing and implementing the HMO Community Benefits Program;

d. A narrative description of the specific community benefits and community services actually provided or proposed. This description may include measurements related to number of patients or health status outcomes; and

e. To the extent feasible, HMOs are also encouraged to establish a Community Benefits budget and to make a good faith effort to measure expenditures and administrative

costs associated with the Community Benefit Program including both cash and in-kind commitments.

Community response to the HMO Community Benefits Program and Reports is encouraged. HMOs are encouraged to solicit and make publicly available comments generated in response to the HMO Community Benefits Program. The long-term measure of the success of an HMO's Community Benefits Program will be improvement in the health status and outcomes of the HMO's designated community.

IV. CONCLUSION

These Guidelines embody the recommendations of the Attorney General to assist HMOs in the development of community benefits programs to help meet the health and safety needs of the communities served by the HMOs. The current changes in health care delivery systems carry a clear challenge to Massachusetts HMOs and to their communities. In the face of increasing competition and economic pressures, the needs of vulnerable and at-risk populations should not be neglected.

With change in the healthcare marketplace already underway, the process outlined in these Guidelines will undergo continued evolution and refinement. Constructive suggestions from all sources are welcome.

V. GLOSSARY

"Health maintenance organization" ("HMO"), as defined by M.G.L. Chapter 176G (1995), means a company organized under the laws of the Commonwealth, or organized under the laws of another state and qualified to do business in the Commonwealth, which provides or arranges for the provision of health services to voluntarily enrolled members in exchange primarily for a prepaid per capita or aggregate fixed sum.

"Member" as defined by M.G.L. Chapter 176G (1995), means any individual who has entered into a health maintenance contract, or on whose behalf such an arrangement has been made, with an HMO or carrier or both for health services, and any dependent of such individual who is covered by the same contract.